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ABSTRACT

Nursing home regulatory agencies are subjected to a variety of pressures. Nursing home residents' families and friends want the agencies to "get tough" while the nursing home industry wants agencies to act as consultants rather than cops. The task of regulating nursing homes in the United States is primarily carried out by units of state government, operating under Medicaid certification guidelines and procedures set by the Health Care Financing Administration. State agencies in fact have enormous discretion as to how the guidelines will be interpreted, what level of compliance will be expected, and when and how non-compliance will be penalized. Data on the imposition of penalties by the states show enormous variations in which penalties (fines, decertification, etc.) are used, and what proportion of facilities are penalized. The states with more facilities are more likely to use penalties; few other correlations appear. (An appendix details the lack of reliable data on regulatory enforcement and the reasons why available data do not permit comparisons of states' enforcement policies.) (Author/ABL)

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COPS, CONSULTANTS, AND GOLDFISH

VARIATIONS IN NURSING HOME REGULATION

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ABSTRACT

COPS, CONSULTANTS, AND GOLDFISH: VARIATIONS IN NURSING HOME REGULATION

John A. Gardiner

A paper presented at the Gerontological Society of America Annual Scientific Meeting, November, 1986

The task of regulating nursing homes in the United States is primarily carried out by units of state government, operating under Medicaid certification guidelines and procedures set by the Health Care Financing Administration. State agencies in fact have enormous discretion as to how the guidelines will be interpreted, what level of compliance will be expected, and when and how non-compliance will be penalized.

Data on the imposition of penalties by the states shows enormous variations in which penalties (fines, decertification, etc.) are used, and what proportion of facilities are penalized. The states with more facilities are more likely to use penalties; few other correlations appear.

An Appendix details the lack of reliable data on regulatory enforcement and the reasons why available data do not permit comparisons of states' enforcement policies.

Every agency which enforces nursing home regulations is exposed to pressures by nursing home residents, their friends and families, and organized advocacy groups to "get tough" on the nursing home industry. Each agency is also subject to industry pressure to be "flexible" in its interpretation of regulations, to be "understanding" in setting timetables for plans of correction, and to act as a "consultant" rather than as a "cop." Each agency is frustrated by difficulties in ensuring that field inspectors carry out central office policies and priorities, by lawyers and judges who find "professional judgment" an inadequate basis for proposed penalties, and by elected officials who craft inconsistent policies and/or call for get-tough policies while they seek breaks for individual constituents or relatives.

While every regulatory system is thus subjected to many divergent pressures, these pressures may not be of equal strength in each state, and the regulators may reconcile conflicting pressures in different ways. To simplify the possibilities, one state's regulators might see themselves as "cops," citing every violation they see, while another state might emphasize a "consultant" role, emphasizing a facility's prompt return to compliance with regulations rather than citations and fines. Other states have directly or indirectly abandoned enforcement strategies and turned to incentives in the hope that the promise of more money will appeal to nursing home operators who have not been deterred by the threat of penalties. (Sceptics in Illinois believe that incentive payments for a "functional and sensory-stimulating environment" have simply led nursing homes to put a tank of goldfish in the day room.) Finally, it can only be said that some states have no coherent policy, mumbling platitudes about "high quality care" while muddling along with minimal resources, no follow-through, and a ready willingness to agree with whoever is complaining the loudest.

Measuring Policy Variations. For twenty years, the nursing home industry has charged that the regulators behave like mindless cops, finding insignificant violations in the shape of place mats, the temperature of fishtanks, and the completion of records that no one reads. Conversely, a series of state investigations, books, and reports by resident advocates have concluded that most regulatory agencies act like spineless consultants, gullibly acceding to whatever promises of compliance are made at the end of a survey. While each side has numerous anecdotes to support its conclusions, it has never been possible to compare state agencies' enforcement policies. Industry and advocates believe that there are significant differences among the states--that a nursing home offering a certain quality of care will be licensed in State X, but that an identical home will be put out of business in State Y; or that two different homes will receive the same treatment by different agencies. Ultimately, validation of these claims is impossible: the only "evidence" of conditions in nursing homes lies in the reports written by the regulators. Two annual surveys which conclude that facilities are in compliance with a nursing care standard, are indistinguishable; two surveys which conclude that one facility is in compliance while the other is not, cannot be deciphered to determine whether the care given in the first facility is "really" better than the care in the second. Just as we have no independent measures of the quality of care, we have no measures of the impact which enforcement has had on regulated nursing homes: one regulatory agency may be able to induce compliance with a friendly word of advice or a stern (but informal) warning, while another agency may impose penalties with abandon but be ignored by the regulated facilities.

Accepting these limitations, a survey of state nursing home licensure and certification agencies conducted in October of 1986 provides an opportunity

to identify rough variations in enforcement practices and the factors which tend to correlate with "tough" and "lax" enforcement styles. Each agency was asked both what sanctions it could impose on facilities which violate state or federal regulations, and how many times it had used each sanction in the past year (calendar 1985 or fiscal 1986). The results of the survey are shown in Table One. The sanctions reported varied in a number of ways. Some (monitors and receivers) restricted the facility's freedom to operate, but did not by themselves have financial consequences. Some forced a total cessation of operations (relocation of residents, license revocation), while others produced financial penalties in varying amounts (fines, bans on admissions, reduced or withheld Medicaid reimbursement).

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMINISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID REIMBURSEMENT
AL ALABAMA	212	20	.09	X	X	X	0	0	X	1	4	X	6	0	1	4	4
AK ALASKA	12	2	.17	X	X	0	X	X	X	X	X	X	2	0	0	0	X
AZ ARIZONA	73	79	1.08	2	X	X	15	X	X	0	6	X	48	2	2	4	X
AR ARKANSAS	214	69	.32	57	X	X	4	4	X	X	2	X	X	1	0	X	1
CA CALIFORNIA	1,379	2,161	1.57	2,081	1	0	0	0	0	2	12	0	4	19	2	21	19
CO COLORADO	182	7	.04	X	0	2	2	0	0	0	0	X	3	0	0	0	X
CT CONNECTICUT	232	6	.03	0	0	5	0	0	0	X	0	X	X	0	0	1	X
DE DELAWARE	31	7	.23	X	0	X	1	0	0	X	X	X	4	1	0	X	1
DC DIST OF COLUMBIA	12	10	.83	X	0	2	2	0	1	X	1	X	2	1	X	1	X
FL FLORIDA	363	186	.51	70	0	0	8	0	0	0	0	X	108	0	0	0	0
GA GEORGIA	323	26	.08	0	X	1	X	19	0	0	2	X	0	0	0	4	X
HI HAWAII	33	0	.00	0	X	X	X	X	X	X	X	X	0	0	0	0	X
ID IDAHO	62	5	.08	X	X	X	X	1	X	X	X	X	4	0	X	0	X
IL ILLINOIS	723	112	.15	61	0	13	X	15	0	0	2	X	16	0	0	5	0
IN INDIANA	460	54	.12	2	0	20	X	0	0	X	1	X	25	1	X	5	X
IA IOWA	423	42	.10	35	0	X	X	X	X	X	0	X	5	1	0	1	X
KS KANSAS	370	81	.22	12	0	1	X	X	X	X	1	X	60	7	X	0	X
KY KENTUCKY	209	16	.08	12	X	X	X	X	0	0	1	X	X	2	0	1	X
LA LOUISIANA	238	53	.22	3	0	0	0	2	0	0	0	X	45	1	X	2	0
ME MAINE	144	3	.02	0	0	X	0	0	0	0	1	0	0	1	X	1	0

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMINISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID REIMBURSEMENT
MD MARYLAND	190	31	.16	X	0	X	4	X	0	0	X	X	25	2	0	0	0
MA MASSACHUSETTS	512	101	.20	X	5	3	15	5	0	2	4	42	14	5	1	5	X
MI MICHIGAN	429	130	.30	50	1	X	1	1	X	0	0	65	0	4	0	8	X
MN MINNESOTA	466	34	.07	34	0	X	0	0	X	0	0	X	X	0	0	0	X
MS MISSISSIPPI	152	2	.01	X	X	X	0	0	0	X	0	0	2	0	0	0	0
MO MISSOURI	304	66	.22	0	1	3	5	0	0	3	0	X	18	31	0	5	X
MT MONTANA	92	0	.00	0	X	X	X	X	0	X	0	0	0	X	X	X	X
NE NEBRASKA	216	17	.08	X	1	X	6	0	0	X	0	X	10	0	0	0	X
NV NEVADA	27	2	.07	X	X	X	X	2	0	X	0	X	X	0	0	0	X
NH NEW HAMPSHIRE	70	3	.04	X	X	X	X	X	X	1	X	X	2	0	0	0	X
NJ NEW JERSEY	242	49	.20	28	2	X	15	0	0	X	2	X	0	0	2	0	X
NM NEW MEXICO	53	0	.00	X	X	X	X	0	X	X	0	X	0	0	0	0	X
NY NEW YORK	583	159	.27	85	8	X	0	7	50	0	0	X	0	8	0	1	X
NC NORTH CAROLINA	227	37	.16	23	X	X	5	X	2	0	0	X	6	0	0	1	X
ND NORTH DAKOTA	82	1	.01	X	X	X	1	X	X	X	X	X	X	0	X	0	X
OH OHIO	879	20	.02	X	X	X	0	18	0	0	0	X	X	0	X	2	X
OK OKLAHOMA	369	7	.02	X	2	0	0	2	0	0	0	2	0	0	0	1	0
OR OREGON	182	118	.65	102	3	0	X	8	0	0	2	0	X	2	X	1	0
PA PENNSYLVANIA	608	131	.22	12	X	2	19	0	0	1	4	X	82	9	X	0	2
RI RHODE ISLAND	107	2	.02	0	X	X	1	1	0	X	0	X	X	0	0	0	X

	CERTIFIED SNF AND ICF FACILITIES	TOTAL SANCTIONS IMPOSED, 1985-86	SANCTIONS PER FACILITY	CIVIL OR ADMINISTRATIVE FINES	COURT-APPOINTED RECEIVER	STATE-APPOINTED MONITOR	SUSPENSION OF ALL NEW ADMISSIONS	SUSPENSION OF MEDICAID ADMISSIONS	REJECTING CON FOR PAST RECORD	COURT INJUNCTION	RELOCATION OF RESIDENTS	REDUCED MEDICAID RATES	RESTRICTED LICENSE	LICENSE REVOCATION	LICENSE SUSPENSION	INVOLUNTARY DECERTIFICATION	WITHHOLDING MEDICAID RE...
SC SOUTH CAROLINA	131	1	.01	1	X	X	X	X	0	0	0	X	0	0	0	0	X
SD SOUTH DAKOTA	117	28	.24	0	0	X	0	2	X	0	0	X	26	0	0	0	X
TN TENNESSEE	248	33	.13	X	X	12	14	X	X	0	0	X	4	1	1	1	0
TX TEXAS	965	450	.47	0	2	X	X	X	X	0	3	X	X	1	0	117	327
UT UTAH	77	3	.04	X	X	X	X	1	X	0	X	X	1	0	0	1	X
VT VERMONT	45	4	.09	0	X	X	0	0	X	X	0	X	4	0	0	0	X
VA VIRGINIA	179	4	.02	X	X	X	2	0	X	0	X	X	X	1	0	1	X
WA WASHINGTON	277	26	.09	7	X	X	14	0	1	X	0	X	X	1	1	2	0
WV WEST VIRGINIA	92	18	.20	0	X	X	X	0	X	0	0	6	10	1	0	1	0
WI WISCONSIN	430	137	.32	136	0	0	X	X	X	0	0	X	0	0	X	1	X
WY WYOMING	27	2	.07	X	X	X	X	1	X	X	0	X	0	0	0	1	X
TOTALS	14,073	4,555	.32	2,813	26	64	134	89	54	10	48	115	536	103	10	199	354
NO. OF STATES WITH SANCTION	----	----	----	31	25	18	31	36	29	30	42	9	39	50	39	48	17

Notes to Table One

As indicated in the Appendix, these data were collected by means of telephone interviews with the licensure and certification agencies in each state and the District of Columbia; the interviews were conducted in October of 1986. If the agency indicated that it did not have data on all sanctions, additional calls were made to the state's Medicaid agency and/or health planning agency. Information provided by the agencies was questioned in only two aspects: they were asked to report only sanctions which had been imposed, not just threatened, and each assault on a facility was to be listed only once (e.g., if the facility lost its license and thereby lost its certification to participate in Medicaid, the event was reported only under license revocation.) These data, and the labeling guidelines which were used, were given back to the states for correction.

x = this sanction is not available in the state.
0 = this sanction is available, but was not used during the year.
"Certified SNF and ICF facilities" = the unduplicated total number of certified skilled nursing facilities and intermediate care facilities (but not ICF/MRs) certified by HCFA in 1984. Data supplied by HCFA.
"Total Sanctions Imposed 1985-86" = the sum of the individual sanctions. States were asked to provide data for the most recent twelve month period possible; some used calendar 1985 and some used FY 1986.
"Sanctions per Facility" = the second column divided by the first column.
"Civil or Administrative Fines" = fines imposed on a facility for violating a statute or regulation. (N.B. this does not include fines imposed on an individual, such as a doctor or aide, working in a nursing home.)
"Court-appointed receiver" = a formal order designating someone to operate a nursing home under court supervision (often during sale or closing of the facility.)
"State-appointed monitor" = a representative of the survey agency or Medicaid agency assigned to scrutinize facility compliance with a plan of correction or performance following a negative survey.
"Suspension of all new admissions" = formal order by the licensing agency not to admit any new residents until specified conditions have been met.
"Suspension of Medicaid admissions" = notification by the Medicaid agency or licensing agency that no new admissions will be covered by the Medicaid program until further notice. (Unless all admissions are banned, however, a facility could still admit new private pay residents.)
"Rejecting CON for Past Record" = An action by the state's health planning agency rejecting an application for a Certificate of Need because the applicant had previously violated long-term care regulations.
"Court Injunction" = a formal order by a court enjoining the facility from future violations.
"Relocation of Residents" = formal action by the state removing residents from a facility, usually undertaken only in life-threatening situations.
"Reduced Medicaid Rates" = reductions in the rate at which a facility participating in Medicaid is reimbursed, because of rule violations.
"Restricted License" = the facility may operate, but under restrictions resulting from previous poor performance (not including probationary licenses automatically issued to new licensees.)
"License Revocation" = involuntary termination or non-renewal of a facility license.
"License Suspension" = short-term loss of license to operate.

"Involuntary Decertification" = involuntary termination or non-renewal of certificate to participate in the Medicaid or Medicare programs.

"Withholding Medicaid Reimbursement" = temporary or permanent decision to deny payment for Medicaid residents already in a facility, due to violation of regulations.

Without implying that these sanctions are of equal significance, Table Two summarizes the total number of sanctions imposed by each state.

TABLE TWO
NURSING HOME SANCTIONS IMPOSED, 1985-86

Number	States
0-10	Alaska, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Idaho, Maine, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Rhode Island, South Carolina, Utah, Vermont, Virginia, Wyoming
11-30	Alabama, Georgia, Kentucky, Nebraska, Ohio, South Dakota, Washington, West Virginia
31-50	Iowa, Maryland, Minnesota, New Jersey, North Carolina, Tennessee
51+	Louisiana (53), Indiana (54), Missouri (66), Arkansas (69), Arizona (79), Kansas (81), Massachusetts (101), Illinois (112), Oregon (118), Michigan (130), Pennsylvania (131), Wisconsin (137), New York (157), Florida (187), Texas (450), California (2,161)

As a rough device to control for the number of nursing homes which the agencies must regulate, Table 3 groups the states by the number of sanctions per 100 skilled or intermediate care facilities certified to participate in Medicaid or Medicare.

TABLE THREE
SANCTIONS PER 100 CERTIFIED NURSING HOMES, 1985-86

Number	States
0-5	Colorado, Connecticut, Hawaii, Maine, Mississippi, Montana, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Utah, Virginia
6-10	Alabama, Georgia, Idaho, Iowa, Kentucky, Minnesota, Nebraska, Nevada, Vermont, Washington, Wyoming
11-20	Illinois, Indiana, Maryland, Massachusetts, New Jersey, North Carolina, Tennessee, West Virginia
21+	Kansas (22), Louisiana (22), Missouri (22), Pennsylvania (22), Delaware (23), South Dakota (24), Alaska (25), New York (27), Michigan (30), Arkansas (32), Wisconsin (32), Texas (47), Florida (51), Oregon (65), District of Columbia (83), Arizona (108), California (157)

No reservations about the interpretation of these data can obscure some of the greater contrasts which are displayed in these tables: between Texas, which imposed 450 sanctions in regulating its 965 facilities, and Ohio, imposing twenty sanctions on 879 facilities; between Florida (186 sanctions, 363 facilities) and Georgia (26 sanctions, 323 facilities); or between Oregon (102 fines, 118 facilities) and Washington (7 fines, 277 facilities). Texas decertified 117 facilities; twenty states decertified none. Fifteen states imposed five or less sanctions per 100 nursing homes; sixteen imposed twenty-one or more (Table Three).

Correlates of Enforcement Policies. To the extent that the data on the total number of sanctions imposed, and the number of sanctions per 100 certified facilities, are indicators of state enforcement policies, are they correlated with other characteristics of the states? This paper reports a preliminary analysis of several aspects of this questions.

Three broad categories of variables will be discussed. (Precise definitions of each variable, and their sources, are reported in the notes to Table Four.) The first consists of variables relating to nursing homes and the elderly in each state. They are the number of certified SNFs and ICFs in the state, the number of nursing home beds per 1,000 persons 65 and over, the occupancy rate of nursing home beds, SNF reimbursement rates, and the percent of the state's population which is 65 and over. A second set of variables concerns social or political issues: party identification, state funding for the Medicaid program, and general liberalism. The final set are bureaucratic variables: total expenditures for the state's nursing home survey program, the number of FTE surveyors per facility, and the total number of sanctions (fines, receiverships, etc.) which are available to the state agency. Table Four shows the correlations among all of these variables.

Several statistically insignificant findings are surprising. While it has often been argued that regulators are unable or unwilling to take action against substandard nursing homes because of high occupancy rates (i.e.,

because there were no vacant beds to which residents could be transferred), Table Four shows virtually no correlation (Pearson's r= -.0033) with Total Penalties and little with Penalties/Facility (-.1863). Similarly, despite the expection that states which pay higher Medicaid reimbursement rates would demand higher quality, the correlations are similarly low (-.0725, -.2111). With reference to the three indicators of policy liberalism (Democratic party identification, state Medicaid funding, and Klingman and Lammers' "general policy liberalism"), correlations with the total number of penalties are generally low (.0866, .1339, .2519); the correlations with Penalties/Facility are somewhat higher (.2359, .3355, and .1405).

TABLE FOUR

CORRELATION MATRIX: NURSING HOMES, LIBERALISM, ENFORCEMENT SYSTEMS, AND PENALTIES

	STATE POPULATION	CERTIFIED FACILITIES	BEDS/ POPULATION	OCCUPANCY RATE	SNF REIMBURSEMENT	PER CENT OVER 65	DEMOCRATIC IDENTIFICATION	MEDICAID FUNDING	LIBERALISM	SURVEY COSTS	SURVEYORS PER FACILITY	AVAILABLE SANCTIONS	TOTAL PENALTIES
CERTIFIED FACILITIES	.9010												
BEDS/POPULATION	-.1030	.2095											
OCCUPANCY RATE	-.0353	-.1171	-.0495										
SNF REIMBURSEMENT	-.0734	-.1418	-.0950	.0099									
PER CENT OVER 65	.0731	.1401	.2303	.2755	-.2692								
DEM IDENTIFICATION	.1098	.0488	-.2828	-.0122	-.1850	-.1863							
MEDICAID FUNDING	.2877	.2323	.0561	.0743	.3762	.1393	-.0778						
LIBERALISM	.3494	.3594	.2193	.1756	.3503	.1997	-.4699	.7181					
SURVEY COST	.6957	.4825	-.1901	.0605	.0853	.2907	.0377	.3212	.2681				
SURVEYORS/FACILITY	-.1253	-.2337	-.2838	-.0676	.2913	-.0105	.2053	.5843	.0421	.0302			
AVAILABLE SANCTIONS	.5254	.4437	-.1159	.2042	-.2375	.3442	.2763	.2511	.2731	.4665	.0086		
TOTAL PENALTIES	.7149	.7105	-.0690	-.0033	-.0725	-.0322	.0866	.1339	.2519	.3944	-.0932	.3808	
PENALTIES/FACILITY	.5082	.4452	-.2605	-.1863	-.2111	.0562	.2359	.3355	.1405	.3447	.2670	.4183	.7427

Notes to Table Four

"State Population" = state population in 1980 census.

"Certified Facilities" = certified SNF and ICF facilities in 1984 (see Table One)

"Beds/Population" = nursing home beds in 1983/1000 population aged 65 and over (Source: Institute of Medicine, 1986:361)

"Occupancy Rate" = percent of all (licensed and unlicensed) nursing home beds occupied (Source: 1982 National Master Facility Inventory, Table 24)

"SNF Reimbursement" = Average Medicaid Rate per Patient Day, FY 1983 (Source: HCFA, 1984: 106)

"Per Cent over 65" = Percentage of 1981 State Population 65 years and over (Source: Institute of Medicine, 1986: 369)

"Democratic Identification" = percentage of state respondents to CBS/ New York Times surveys 1976-1982 identifying themselves as Democratic (Source: Wright, 1985: 476)

"Medicaid Funding" = the state share of Medicaid payments in FY 1983, divided by the state's population (Source: HCFA, 1984:145)

"Liberalism" = General policy liberalism score developed by Klingman and Lammers (1984:602-3) aggregating six indicators of innovativeness, anti-discrimination, AFDC payments, Title XX payments, speed of ratification of Equal Rights Amendment, and consumer-oriented policies.

"Survey Cost" = total state survey agency licensure and certification expenditures, FY 1983 (Source: Institute of Medicine, 1986: 330)

"Surveyors/Facility" = state survey agency FTE employees in 1984 engaged in licensure and certification activities (Source: Institute of Medicine, 1986: 331) divided by the number of certified facilities. (N.B. seven states did not supply this data for the IOM survey, but supplied it in the course of our 1986 telephone survey).

"Available Sanctions" = the total number of sanctions which states <u>can</u> impose on nursing homes (see Table One).

"Penalties/Facility" = Sanctions per Facility from Table One

By far the strongest correlations with Total Penalties and Penalties/Facility involve the variables which deal with the magnitude of the regulatory workload and the resources available to handle it: with state population (.7149, .5082), with the number of certified SNFs and ICFs in the state (.7105, .4452), with the costs of the survey program (.3944, .3447), and with the number of available sanctions (.3808, .4183); the number of surveyors per facility was moderately correlated with the number of penalties per facility (.2670) but not with the total number of penalties (-.0932).

To sort out the contributions of these variables, all were included in stepwise regression analyses of the two dependent variables. From each analysis, a model containing not more than three significant variables emerged.

$$\text{TOTAL PENALTIES} = -582 + .4203\ \underset{(1.57)}{\text{CERTIFIED FACILITIES}} + .00002\ \underset{(1.62)}{\text{STATE POPULATION}} + 4.9027\ \underset{(.54)}{\text{OCCUPANCY RATE}}$$

$$R^2 = .5362$$

$$\text{PENALTIES/FACILITY} = -.23 + .0005\ \underset{(3.24)}{\text{CERTIFIED FACILITIES}} + .5083\ \underset{(3.07)}{\text{SURVEYORS/FACILITY}} + .0259\ \underset{(1.74)}{\text{AVAILABLE SANCTIONS}}$$

$$R^2 = .3824$$

In other words, the total number of penalties imposed in a state is strongly related to the state's population and total number of nursing homes. The occupancy rate adds very little to the regression equation (there was a 59% probability that this number would occur by chance.)

The penalties/facility equation suggests three interpretations:

1) Agencies which regulate more nursing homes tend to act more formally, i.e., by imposing sanctions rather than "working with" facilities to bring them into compliance.

2) Enforcement policies may be reflections of staff resources: to the extent that imposing a penalty involves additional work, the agencies with a higher surveyor/facility ratio may be more able to penalize.

3) The availability of additional sanction alternatives may make the states more willing to act (or the facilities less interested in resisting) than if the only option is the drastic step of delicensure or decertification. (Table One, for example, shows that in almost every state, the vast majority of penalties are fines or restricted licenses; overall, they constitute 74% of the penalties imposed in 1985-86.

Policy Implications. Analyzing state enforcement policies on the basis of the types of data used here is both scientifically risky and substantively debatable. As is detailed in the Appendix, a state may take many steps to enforce its nursing home regulations without invoking the penalties studied here; and consultation and other forms of informal suasion may well be very

effective. To the extent that formal actions -- penalties -- are deemed to be necessary components of a state's enforcement program, however, this analysis has several policy implications. While the regression analyses suggest that the states with few nursing homes will be unlikely to adopt "cop" styles, the larger states may be more likely to impose sanctions if they have larger staffs and more sanctions to choose from. Unlike the Wizard of Oz, it is impossible to order a regulator to be courageous, but it is possible to provide the staff and armaments which will make courage efficacious.

NOTES

1. I wish to thank Val Poliny and Leta Dally for their assistance in the collection and analysis of the data used in this report, and Mary Lou Mendoza for her assistance in preparing the manuscript.
2. Similarly, it is widely accepted that there are substantial variations among surveyors working in the same agency, and between surveys of the same facility in different years.
3. The limitations inherent in attempts to measure quality of care and enforcement activities are analyzed in detail in the Appendix.
4. Every state has an agency (often part of the health department) which determines whether a nursing home complies with state licensure requirements. If the facility wishes to participate in the Medicaid and/or Medicare programs, the agency also surveys to determine whether it meets federal requirements; annually, the agency must certify to the Health Care Financing Administration that the facility is in compliance with standards or is in the process of attaining compliance.
5. In addition to the certified SNFs and ICFs, the agencies also regulate certified facilities for the mentally retarded and uncertified facilities, and look for unlicensed facilities.

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APPENDIX

MEASUREMENT ISSUES IN THE STUDY OF REGULATORY ENFORCEMENT

> I have endeavored to sum up the
> evidence upon the case, as fairly as I can;
> and the result seems to be, that the world
> must vibrate in a state of uncertainty
> as to what was the truth.
>
> Boswell (1904:127)

This study has been based upon a variety of sources of information about nursing home regulatory practices; I hope that it accurately depicts the diversity of forces that influence the regulatory process. Even if I have achieved that goal, however, the reader must understand that virtually no systematic, nationwide "objective" information exists about the enforcement of nursing home regulations. Nothing is known about "real" conditions in nursing homes, about the criteria used by regulators to evaluate those conditions, or about informal coercive measures used by them to attain compliance. This Appendix discusses the sources of this information shortage, and its implications for research efforts.

I. Violation-Detection Systems. In an extensive survey of the sources of data on "white-collar law-breaking", Albert J. Reiss, Jr., and Albert D. Biderman noted that

> How an organization comes to know about law violation depends upon its mobilization strategies to detect violations in its environment. The organization can rely primarily upon agents who are outside of it and who are not under its control to bring matters to its attention. Only then does it react to these matters by investigation and other forms of resource mobilization (reactive mobilization). An organization may also seek out violations in that environment by organizing its own modes of detection (proactive mobilization). One must also bear in mind that these proactive and reactive strategies of mobilization pertain to both internal and external environments of an organization, i.e., there are both internal and external environments and internal and external intelligence capabilities related to these environments. (Reiss and Biderman, 1980:108-109; emphasis in original)

Illustrating the violation-detection mechanisms available to an archetypical enforcement agency, Reiss and Biderman present the following typology:

MOBILIZATION STRATEGIES	ENVIRONMENT	
	INTERNAL	EXTERNAL
PROACTIVE	Internal AUDITS of organizational records, practices, etc.-- usually designated Audits Internal Inspections by monitors, tests, etc.	Reporting requirements submitted by agencies Self-reporting of violations required Audits Monitoring systems to detect violations Inspection systems to detect violations
REACTIVE	Investigation of complaints arising internally and externally on personnel Referral for criminal prosecution	Complaint investigation procedures on external referrals under agency mandate Referral for criminal prosecution

(Reiss and Biderman, 1980:112)

As has been evident throughout this study, the states vary widely in the total resources devoted to the collection of information regarding nursing homes, in their capacity (and motivation) for reacting to complaints, in their utilization of proactive data-gathering beyond the mandatory annual surveys, and in their dependence upon data provided by the regulated facilities. Thus they will vary in the total volume, currency (length of time since the latest on-site inspection), and breadth of information sources.

An additional source of variation arising from detection systems concerns the practice of "targeting". Some states view all nursing homes and all regulations equally, even if it means using resources to appraise facilities which have never had problems before or verify compliance with regulations which have never before been broken. Other states may target their resources on the facilities with the worst records and/or the violations which occur most frequently or have the greatest potential costs to residents. (This of course assumes that agencies know which facilities have the worst records, or which regulations are at greatest risk. Unfortunately, Reiss and Biderman note, most regulatory agencies' inspection "strategies are based on presumptions that the modal violator in the system is a first rather than a repeat offender. Because of this assumption, most information systems do not track persons [or organizations] but rather violations..." Reiss and Biderman, 1980:124-125; emphasis in original.) As a result of these variations among states in their configurations of proactive and reactive violation-detection systems, we must assume that some states know more about their nursing homes than do other states, and that some states may know (via targeting policies)

more about some facilities than they do about others. What is unknown is which states are which. We do not know that State X ignores complaints, that State Y ignores all regulations unrelated to nursing care, that State Z has a "hit list" of facilities it wishes to drive out of business. When we see, therefore, statistics on the number of violations cited by each state, or the number of penalties imposed, we do not know whether they mirror differences in the nursing homes' quality of care, or differences in detection systems; one state may cite many violations because it investigates more often or more thoroughly or more efficiently (looking where violations might be expected), while another state may have few violations simply because it was not looking in ways which would uncover problems. Finally, reiterating the last comment from the Reiss and Biderman study, the emphasis in most information systems on violations rather than violators means that researchers and policy-makers can't ask, across state lines, whether certain characteristics of facilities (size, age, ownership, case-mix, etc.) are related to care; the detection-system variations will obscure any relationships which may exist.

II. Inter-Agency Data Issues. The task of regulating nursing homes is shared by many agencies in each state, including the licensing and certification agency, the Medicaid agency, the agency which grants professional licenses for nurses and administrators, and the Attorney-General. Each of these agencies maintains its own information system. Within each agency, separate information systems may track the efforts of sub-units -- surveyors, complaint investigators, attorneys, etc. Reiss and Biderman term these information systems "disjunctive." "It is characteristic of these information systems that they are discretely organized, each around its own set of cases, that only a minimum of information is exchanged when a case is an output transaction to another organization and that often no attempt is made to track a case beyond its point of transfer to another organization. When it is tracked, each organization records its own information about 'the case.'" Among the consequences of this disjunctiveness, they note, are information-processing based on cases rather than the people or organizations being regulated (thus ignoring information which might explain behavior); interorganization linkage through networks rather than systemic properties (thus precluding analysis of the flow of cases through the entire system); differential, and frequently incomplete, information about matters unrelated to a specific decision; and inability to compare conduct across organizations. (Reiss and Biderman, 1980: 133-134)

I have previously noted the varying priorities of these agencies -- some may want to maximize quality of care, some may want to maximize beds available to welfare recipients, some may want to maximize public visibility (a splashy courtroom victory), some may want to minimize effort, etc. Because of these differences in priorities, the agencies' information systems will contain different data. They will not only record different subject matter (vacant beds, Medicaid accessibility, infection control, court calendars, and so forth), but they will vary in the extent of their coverage: some may deal only with current cases (Should nurse Jones lose her license? Should Restful Hills be fined $1,000?), while others will amass histories of the performance of a facility or professional.

Even if (which is not always the case) the agencies wish to assist each other in the execution of their duties, these information system disjunctions will mean that they can't. None of the agencies can "push a button" and call up the collective knowledge of all agencies. I refer not simply to the lack of shared computers; they organize, process, and store (if at all) information differently. With regard to the same facility, the survey agency will "know"

that it had twelve "C" violations, the Medicaid agency will know that 78 residents are receiving care at the skilled level, the licensing agency will know that delicensed Nurse Jones used to work there, and the Attorney General will recall a resident abuse case dismissed for lack of evidence. Staff members may be able to tap their collective memories, but no more systematic synthesis is possible.

A final aspect of this inter-agency issue concerns each agency's operating routines. Quite simply, few regulators even check to see whether another agency may have relevant information. Prior to conducting an annual survey, the survey agency does not ask the Medicaid agency if the facility's most recent Inspection of Care reports were satisfactory, or ask the professional licensing agency if there have been complaints about the staff, or ask the Attorney General if charges are being investigated. As outlined above, no two agencies define things similarly, but they don't make efforts to share what they do know.

III. Discretion in Labeling. "A principal source of variability in collecting information lies in the discretion of officials to determine the threshold of what it is about information that opens it to treatment as a potential violation of law. . . The critical decision in accessioning matters for any agency is what is to be made a matter of record. . . . What will be treated as a matter of record within an agency will depend upon criteria and decisions about what matters have a future course within the organization in the sense that some resources will be devoted to them, even if only superficially, rather than their being referred elsewhere." (Reiss and Biderman, 1980: 144-145, emphasis in original.)

With regard to labeling nursing home violations, agencies and surveyors have wide discretion regarding when and what violations will be recorded. Regarding the timing of a formal label of deficiency, policies and practices vary enormously, both among states and among surveyors. A non-compliant situation could be labeled (officially designated) (1) as soon as an inspector observes it, (2) if it remains non-compliant when the inspector is about to leave a facility, (3) if the inspector's supervisor concurs in the labeling, (4) if the agency director concurs, (5) if some external agent concurs (a hearing officer, a judge, etc.), or any combination of these. Some agencies may keep statistics based on the initial appraisal of non-compliance (the survey, the complaint investigation), while others may only store information on the events which survive screening. With regard to facilities seeking initial licensure or re-licensure, some agencies may withhold the license until compliance is achieved, while others may license "subject to a plan of correction." In summary, violation data from one state may "look bad" (showing many deficiencies in many facilities) simply because it reports everything ever observed, while another state may report only those problems remaining after an opportunity to correct and an agency review process.

The participants in debates over nursing home issues have defined quality care in different ways. Some emphasize physical issues -- building safety, sanitation, and so forth, while others focus on health issues -- is the resident receiving the medical and nursing care appropriate to his or her condition? More recently, nursing home advocates have tried to focus attention on the "quality of life" -- whether, as Bruce C. Vladeck summarizes the issue, "the food is palatable and tasty as well as minimally nutritious; whether the facility is clean and pleasant; whether there are activities that truly engage the residents' interest as well as meeting formal regulatory requirements; most crucially, perhaps, whether the paid staff are nice to and caring about the residents." (Vladeck, 1980:356)

The enforcement data collected and stored by a survey agency may address all of these issues. It is more likely, however, that the data are selective and non-representative, emphasizing and de-emphasizing things the agency and the surveyor feel are more and less important.

1) Visits by regulatory agencies to individual nursing homes are usually very infrequent. Unless an agency uses the Inspection of Care program as an opportunity for virtually continuous on-site monitoring of care, or investigates complaints frequently, it will only observe conditions once or twice per year, often on a schedule predictable to the facility. Furthermore, almost all inspections are conducted between 9:00 a.m. and 5:00 p.m., between Monday and Friday. Unless the agency has decided to declare war and conduct a midnight raid, it will know nothing about what happens nights and weekends.

2) While this is changing to some extent under the LTCSP survey system inaugurated in 1986, most of the on-site efforts of inspectors are concerned with procedural matters and detailed examination of a few residents most likely to have been treated poorly. The LTCSP sampling process provides more information than its predecessor, but does not try to identify the distribution of levels of quality (the proportions of excellent, adequate, and substandard care); unless investigation identifies a specific instance of deficient care, everything is assumed to be acceptable. The process, in other words, is oriented toward the detection of failures rather than the measurement of "normal" quality. A regulatory agency may be able to report that a nursing home abused a resident or failed to care for her condition; it cannot say whether in other respects the home is outstanding or merely acceptable.

3) The measurement tools applied by inspectors are better equipped to assess physical or medical issues than quality of life issues. Whether because of the "minimum standards" origins of regulation, or because of the fear of litigation, or because of the backgrounds of many regulators, the emphasis has been on things that can be more readily measured and written down. Vladeck's desiderata of "tasty" food, "pleasant" surroundings, "interesting" activities, and "caring" staff members can be assessed, but the current routines of inspectors do not do so.

4) The most important reason why we do not know, in any uniform sense, what quality of care is being provided in each state is that the data which are available are fundamentally reflections of regulatory policy. We do not know that a nursing home is doing a good job treating stroke and a poor job treating dementia; we have instead a regulator's report that the home is or is not complying with a regulation. The state surveyors may have very different beliefs as to what care is appropriate, and they (and/or their supervisors) may have very different norms as to when the care being offered is sufficiently "deficient" to be reported. The same objective conditions may be regarded as acceptable by Inspector A, deficient but meriting only oral admonishment by Inspector B, or worthy of an official violation notice by Inspector C. The third action may be overruled by a supervisor or judge; the first two actions are almost never scrutinized. We are left with data, as a result, which show that one nursing home was cited for a deficiency and the next nursing home was not; we do not know whether they were of equal quality.

5) Finally, regulators act in different ways after they conclude that a deficiency exists. By some process which may be influenced by official guidelines (written or unwritten), conclusions are reached as to the "seriousness" of the violation, and the regulators will translate some of the perceived deficiencies into a set of written records. In some states, a report may cite one instance of a failing (Jane Smith's dressing was

unchanged), while other states will label every instance as a separate violation (10:00 p.m. medications were not given to Jane Smith, Mary Jones, or Pat Brown, on Tuesday, Wednesday, or Thursday.) The first would appear as one violation, the second would be nine.

A second variation concerns the level of generality cited. The forms used in HCFA certification surveys permit a violation to be cited at the "element" or at the Standard or Condition level. (E.g., a surveyor could say that a facility failed to provide "24-hour nursing services which are sufficient to meet total nursing needs" (element F135) but not label the standard of twenty-four hour nursing service "not met.") Documenting the lack of uniformity on this issue, the Institute of Medicine's Committee on Nursing Home Regulation in 1984 asked the state survey agencies "how many standards have to be deficient for the nursing services condition to be marked 'not met'?" Only two states said "any one." Five cited specific standards which would have this consequence; 36 said "it depends." (Institute of Medicine, 1986: 338).

A third variation concerns data-retention after a problem has been corrected. If a violation has been cited -- e.g., in a survey report -- and is thereafter corrected, is it retained in some institutional memory? Some agencies will record the event as (1) a violation which was (2) corrected; other agencies will erase the record, unless it has already been reported to a court, to HCFA, or some other external body. The first type of state would appear to have facilities of poorer quality than the second's.

IV. Surveys of State Enforcement Systems. There is no national archive of information on federal, state, or local nursing home regulatory enforcement. HCFA maintains the Medicare/Medicaid Automated Certification System (MMACS), which includes some information on each nursing home certified to participate in the federal programs, but the information is often one to two years out of date. In 1986, the Inspector General of the Department of Health and Human Services reviewed case files on 1,500 nursing homes, looking at both data in MMACS and data in the state files. "All told, an average of 107 days was required -- 73 by states and 34 by HCFA -- to input the data" into MMACS. (Kusserow, 1986) (The strengths and limitations of MMACS both as a management information system and as a research resource are detailed in Blandford, 1983.) The only enforcement-related information generated by MMACS comes from the most recent survey of each facility (e.g., that a facility was not in compliance with standards A,B, and C); the data are also aggregated to the state and (federal) regional level, e.g., showing that 12% of the SNFs in Connecticut were not in compliance with standard A as contrasted with only 7% in Arkansas. MMACS shows that a July, 1986, survey found a violation of Standard X in Facility Y, but it shows nothing about the state's response to the violation (fine, receiver, plan of correction, etc.) A 1983 evaluation of MMACS records particularly cautioned against comparing data across state lines, citing variations in survey procedures, in licensing vs. certification systems (i.e., some states have more detailed licensing standards or penalization procedures, and for that reason make less use of the certification mechanisms which appear in MMACS), in survey team composition and discretionary policies, and in treatment of dual certification data. (Blandford, 1983: IV-15 -- IV-16).

HCFA does not keep records on the frequency with which states take enforcement actions against sub-standard facilities. It does, however, collect some information about the administration of state survey programs, and intermittently "validates" state surveys by sending federal surveyors into a facility shortly after a state team has left (leading to a report which says

we found X but the state found Y). In an annual assessment (the Comprehensive Evaluation Report, or CER), the HCFA Regional Office critiques each state's survey activities, but the CER stresses administrative issues (especially the timeliness of state reporting to the Regional Office) and state adherence to federal policy interpretations.

Several national surveys have provided extensive information about the state survey agencies. Between 1972 and 1979, HCFA conducted four biennial surveys of state surveyors, collecting information on surveyors' backgrounds, work responsibilities, and training (HCFA, 1980). In 1983, the Association of Health Facility Licensure and Certification Directors (the heads of the state survey agencies) collected basic facts about the management of survey programs, survey procedures and finances, staffing, the facilities inspected, and involvement in other activities such as complaint investigation and certificate-of-need programs. (AHFLCD, 1983) Neither the HCFA surveyor surveys nor the AHFLCD survey collected information on enforcement policies or the use of penalties.

In 1984, as part of its comprehensive study of long-term care regulation, the Institute of Medicine Committee on Nursing Home Regulation sent an extensive questionnaire to the state survey agencies, covering the organization of their nursing home activities; agency personnel, budget workload, and training; state licensure standards; survey procedures; enforcement; and attitudes about federal regulations. The questionnaire, and a summary of the findings, are presented in Institute of Medicine (1986: Appendix C). While the IOM survey and the 1986 Report provide invaluable information about agency structures and procedures, some of the survey's data on enforcement proved limited or unreliable. Four states did not respond to the questionnaire at all, and another twelve did not answer many of the enforcement questions. More important was the fact that the states answered some questions unevenly (e.g., some would report having a sanction only if they had <u>used</u> it while others would report that a sanction was available to them whether used or not), and many of the survey agencies left blank questions which fell within the jurisdiction of another agency (e.g., a Medicaid agency or health planning agency.) The survey agencies' responses to the IOM questionnaire proved to be quite reliable on administrative and attitudinal issues, but the enforcement data could not be used for comparative analysis.

V. <u>The 1986 Survey on Sanctions and Penalties</u>. To remedy gaps in the data from the IOM survey, the data used in this analysis were gathered via a combined mail and telephone survey in October of 1986. Each survey agency was sent a two-page questionnaire; ten days later, the agencies were called to collect the information. After they reported their data, they were asked whether it included duplications (whether several penalties dealt with the same sanctioning event) and whether other agencies (e.g., Medicaid or health planning) should be contacted for additional information. After such additional leads were pursued, data was sent back to the survey agencies to check for mistakes or gaps. Each state, in other words, has seen how we have classified their data and has had an opportunity to correct it.

While we believe these data are "correct" in a quantitative sense (State X issued Y fines in 1985), they also can be very misleading. In addition to the generic problems discussed in Sections I-III of this Appendix, the following problems should be understood:

1) There is no reason to assume that the fifty-one regulatory programs are dealing with equivalent nursing homes. While statistics are available on the size and level of care (e.g., SNF vs. ICF) of each state's facilities, we

have no way of knowing whether one state's nursing home industry offers better care than another's, whether one tends to comply the moment a deficiency is cited while another waits until license revocation is threatened, etc. Thus, fundamentally, we cannot say that each state is dealing with the same regulatory task.

2) Similarly, the state's enforcement statistics in a particular year may conceal the effects of a number of historical factors. At the level of individual interactions (Pat Smith inspecting Jones Manor), the inspector may be bearing the scars of prior combat ("I got clobbered at a hearing once when I cited them for poor sanitation", or "they helped me out at the beginning when I didn't know how the regulations worked"). At a more systemic level, the nursing home industry being regulated in 1986 may have been purged of the "rotten apples" in 1976, or the agency may have learned in 1976 that aggressive policing will be frustrated in the courts or the legislature. For shorter periods of time, all inspectors may be rigid after a catastrophic nursing home fire, or timid after a publicized act of overzealousness (one state's public health director was humbled at an industry banquet by an "award" commemorating a deficiency given by one of his sanitarians; the inspector had cited a facility for having toilet paper which rolled <u>toward</u> the wall rather than out over the top.)

Historical influences such as these are universal -- all states experience ebbs and flows of regulatory zeal -- but it is impossible to tell where each state stands at the time of a study such as this. A state may have issued few sanctions in 1986 because it issued many sanctions in 1985 ("cleaning up the problem"), because the industry has just won a political victory, <u>or</u> because it doesn't believe in issuing sanctions.

3) While every state must apply the same federal certification standards, the states vary in the nature and extent of <u>licensure</u> requirements. The statistics reported to us <u>may</u> reflect varying responses to comparable expectations <u>or</u> they may be parallel to varying standards (one state may issue hundreds of penalties for violations of a requirement which does not exist in another state.)

4) Our telephone interviews with the states revealed many variations in state policies about when enforcement actions against a facility became "statistics," confirming a suspicion discussed in Section III, above. Some states openly reported that they "didn't bother" with sanctions until they had given up all attempts at informal suasion and were going for delicensure or decertification. Other states, by contrast, issued warning letters, fines, or even "intent to decertify" letters as soon as a survey reported a significant deficiency. Further, some states were quite ready to terminate providers who had not come into compliance within a few weeks but equally ready to re-enroll them as soon as compliance was attained. Other states were reluctant to terminate but adamant against re-enrollment.

5) Even though we asked the states to remove duplications, it is unlikely that, particularly in the more active states, every penalty recorded in Table One represents a separate event. As discussed earlier, State A may issue one penalty for a nursing care violation when State B issues separate fines for each resident neglected. Similarly, one state may issue a second penalty for a deficiency not corrected since an earlier survey, while a second state may stick with the initial penalty or even withdraw it if the problem has been corrected.